

HCB Setting Changes – Improving lives



home & community-based settings

Developed by the
Wyoming HCB Setting Transition Taskforce

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HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

Table of Contents

New Federal Rules.....	4
Purpose of these changes.....	4
Our Approach.....	4
Provider Next Steps regarding HCB Setting Compliance	5
Role of Case Managers, Participants, & Guardians	5
Rights specified in the new rule	7
Process to Restrict a Right, if needed	8
Advice to Providers.....	9
Example of a Provider Transition Plan.....	16
Key Terms - Definitions and Guidance.....	17
Integration.....	17
Inclusion	19
Institutional Qualities (what we don't want to see)	20
Informed Choice	21
Focus on Friendships.....	22
Access to food when a person wants to eat.....	24
Signed Lease or Residency Requirement.....	24
Access a Lockable bedroom door and front door.....	24
Guardian Input and Decision making.....	25
Ideas for Sparking Change!	25



HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

“Community integration efforts help bring federal funding for disability-related services into alignment with the 1999 Olmstead decision, which requires services to be delivered in the most integrated setting possible. People with disabilities have fought for decades to make meaningful choices about community-based options a reality. We believe that all people should have the right to stay in their own communities, and that it is imperative for the past several decades’ move away from institutions to continue... This work will ensure that many more people with disabilities have the opportunity to transition out of unnecessarily restrictive settings and live in fully integrated communities.”

Ari Ne’eman
President, Autistic Self Advocacy Network
Washington, DC

New Federal Rules

In March 2014, the federal government passed new rules for the types of services that can be covered through Medicaid-funded home and community-based (HCB) services. The new [Home and Community Based Setting federal regulations](#) are found at 42 CFR 441.301(c)(4)-(5). The new rule will help make sure that people who use the waiver HCB services are truly integrated into their communities. States will not be allowed to use federal Medicaid dollars to pay for HCB services in settings that isolate people from the community or that do not show respect for people’s right to privacy, dignity, and self-determination.

Purpose of these changes

The purpose of the new rule is to make sure that states use HCB funding for programs that truly work to integrate people with disabilities into the community at every opportunity. The rules set forth that services in group settings that isolate people from the community will no longer be allowed at the end of the transition year of March 2019. The rules require providers to ensure services are provided in a setting that gives people real opportunities to work, live, socialize, and fully participate in the community.

Our Approach

The federal agency that oversees the HCB waivers, the Centers for Medicare and Medicaid Services (CMS), understands that states may need time to get all of their HCB settings into compliance, so they allowed states five years from the effective date of the new rule (March 17, 2014) to develop a transition plan for compliance. Wyoming’s transition plan for the Supports, Comprehensive, Acquired Brain Injury, and Assisted Living Facility waivers include a detailed review of providers settings that took into account provider’s survey responses, evidence provided, and a review of incidents, complaints, the past year’s site survey, participant plans of care, and other collateral information. With help from an active Transition Taskforce, which includes members from large and small providers, case managers, parents, waiver participants, state agency staff, advocates, lawyers, and a psychologist, the recommendations for making changes in HCB Settings are included in this guide.



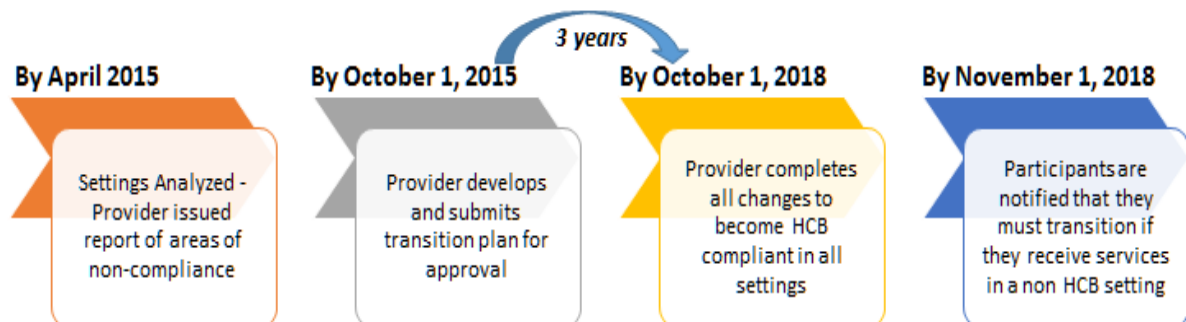
HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

Provider Next Steps regarding HCB Setting Compliance

In Spring 2015, the state completed an evaluation of provider HCB settings in Wyoming, which assessed whether the settings were in compliance with each part of the new rules. For any findings of noncompliance noted in their report, the provider must develop a transition plan to come into compliance by October 1, 2018. Once a provider receives their final HCB compliance report, they must develop and submit a transition plan to the Division by October 1, 2015. The plan must outline the steps they will take to come into full compliance with the new rules by October 1, 2018. Transition plans should ensure that each area of compliance is systematically applied in the organization and all participants are afforded the rights listed. Provider policies and procedures should be updated to align with these standards, and they should be implemented with training, then evaluated regularly to see if they are being practiced as designed. Annual progress on the transition plan is required and must be reported to the Division *each year* by October 1. However, if concerns arise with these areas due to incidents, complaints, or site visit observations, the Division may issue corrective action to address differently than the timeline or process reported in the transition plan. Provider Transition Plans are due by October 1, 2015, and the designated Provider Support Specialist will review it for approval or changes by October 31, 2015. Transition plans must include detailed milestones for each area of non-compliance, action steps, and deadlines. A template for a transition plan is available on the Division's website.

NOTE: For any new findings of noncompliance found through site surveys, incident or complaints, representative sample case reviews, or stakeholder survey responses, which are cited after the date of their report, a modified transition plan will be required to include the new area(s).



Role of Case Managers, Participants, & Guardians

As providers address the areas of non-compliance within their business, they may be changing policies, processes, and day-to-day operations. It will be important during these next few years to meet with the leadership of the organization, read through their plans for change, and give your input. Ask them questions if you wonder when they will be addressing a certain area and how it may affect you, service delivery, documentation, or the participant's life.



Questions

If you have questions regarding the state's approach to these new HCB requirements, please contact BHD at bhdmail@wyo.gov or 1-800-510-0280.



HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians



What is your typical day?

A person in home and community based waiver services needs to design and choose what their typical day looks like. And it should resemble days that people without disabilities get to live.

They should not be limited by unfair barriers or challenges that are not typical barriers for those NOT receiving HCBS services.



As a case manager, provider, family member, or guardian, we want you to ask yourself, Would I like to live the way this person is living?

Would I be okay with my child or sibling receiving services in this setting?

*If the answer is **no**, then the plan of care team needs to keep advocating and working with the participant, providers, family members and community members on using person-centered practices to help the participant live a meaningful life that he or she designs! No one should settle for a life that makes them bored and unhappy.*

HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

Rights specified in the new rule

For each service setting within a provider facility, the new HCB rules specify that a waiver participant receiving services shall have the following rights and freedoms.

Settings that are integrated within the community so the participant can:

- Receive services in the community to the same degree as those not receiving HCBS
- Receive services in a setting that is not segregated from people receiving services without disabilities
- Receive services in a location among other private residences and retail businesses, in an area with consistent traffic patterns and where visitors are present and visiting regularly

A choice in where to live with as much independence as possible, in the least restrictive environment, and:

- Be given opportunities to visit other settings options, such as an apartment, smaller home, fewer roommates, private bedroom
- Choose a specific roommate or opt for a private unit.
- Have a unit with entrance doors lockable by the individual, with only appropriate staff having keys/keycodes
- Access to the typical facilities in a home, such as the kitchen, dining area, laundry, and comfortable seating/lounging areas
- Have a signed lease or written agreement with tenant/landlord protection to document protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law
- Have a setting physically accessible to the individual
- Have unrestricted access in the setting to roam to common areas

Exercise Informed Choice and be able to:

- Choose the living environment, services, providers and types of supports based on one's needs and preferences
- Optimize one's initiative, autonomy, and independence in making life choices, in such activities as daily activities, physical environment, and with whom to interact
- Design a schedule that meets one's wishes and is reflected in person-centered plan
- Participate in unscheduled and scheduled access to the community, can come and go at any time, and not have a regimented routine

With freedom comes great responsibility...

We spend a lot of time in this manual discussing the rights that people have in waiver programs, even if they have a legally appointed guardian. Rights listed in the new rule cover topics we have not been as specific on in the past.

Many people have voiced concern that if some participants are given the right to food, a key, visitors, or spending money that they will harm themselves.

In order to help IPC teams explore the rights a person should have "restored" due to these new rules, teams must work together to offer options and information regarding choices and rights, then be willing to have good discussions with the participant and maybe even the guardian on how acting on rights and making choices have risks and possible consequences (positive or negative). The teams should proceed with building backup plans where there are risks, in case mistakes or accidents occur.

Mistakes are a part of life though, so if a person makes a mistake when exercising their right, it doesn't mean there should be a permanent restriction to it in the future.

Learning comes from experiences and we need to encourage people on the waiver to have new opportunities and experiences so that they are better informed!

HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

A setting that ensures one's rights and protections so the participant can:

- Actively participate in the development of a person-centered plan of care
- Have dignity and respect, where people communicate and interact respectfully. Staff greet and converse with participants without talking down to them or acting as though the person is not present and talking around them to other staff
- Expect privacy with protected health information and know that personal care is conducted privately, with help only as needed
- Control personal resources
- Be free from coercion and restraint
- Have visitors of their choosing at any time and access to a private area for visitors
- Have access to make private calls, text, email at their preference or convenience
- Choose when and what to eat and have access to food at any time, and chooses with whom to eat or to eat alone
- Have appropriate clothes for their preferences and the weather and activities performed
- Furnish and decorate their sleeping or living units within the lease or other agreement

A setting that optimizes personal autonomy so the participant can:

- Engage in community life
- Engage with friends and family
- Have support to control their own schedules and activities, and access to activities of his/her choosing in the larger community
- Make money by accessing and seeking employment
- Work in a competitive integrated setting

Process to Restrict a Right, if needed

Many people are concerned that these areas of compliance in the new rules do not apply to participants with certain needs. However, the federal rules allow for a right to be restricted when and if it is absolutely necessary. For a participant who has a need for a right to be restricted, the person and their team must make decisions based on that person's assessed need for a restriction, and not base a decision solely on a diagnosis, medical condition or a possible behavior that happens on occasion. Health and safety concerns addressed by a restriction must not be based on general fears or concerns because of the person's disability or be based on provider convenience because of other people served in the home. The new federal rules specify that any modification or restriction of a right must meet the following requirements and be documented in the plan of care:

- 1) Identify the specific and individualized assessed need.
- 2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- 3) Document less intrusive methods of meeting the need that have been tried but did not work.
- 4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
- 5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- 6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- 7) Include the informed consent of the individual.
- 8) Include an assurance that interventions and supports will cause no harm.

The participant must have all rights honored until there is a reason to restrict a right that has been prior approved in the plan of care. Rights are not privileges or things that people have to earn.

HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

Advice to Providers

Guidance for achieving compliance. The table below shows the areas of compliance from the new federal rule. Provider Service settings, and during the provision of services outside of settings, providers must be able to demonstrate how they adhere to these standards. They must be able to show evidence of how they meet standards when the state conducts ongoing compliance assessments and additional provider surveys in future years. Guidance and examples have been provided to providers and now to all other stakeholders that work with providers, so we can all work on improving our waiver system.

HCB Compliance Area	Guidance for all providers to make system improvements in their organization
1. The setting does not provide people with disabilities multiple types of services and activities on-site.	<p>Participants should have the opportunity and support to attend civic, religious, arts, educational, and recreation activities off site. Therapies and professional services, such as a barber, grocery shopping, or doctor appointments, should be held in community locations.</p> <p>Providers should make sure these options for services are regularly presented as the first option to each participant.</p>
2. Participants in this setting interact with members of the community whenever they please.	<p>Staff should receive training on how to encourage participants to communicate and interact with members of the community. Participants should drive the choice in events and activities in the community, with reasonable policies to accommodate multiple different requests. We recommend that each provider develop a policy for how staff should support participants in the community and develop training or demonstrations to ensure they understand what is expected.</p>
3. Participants have safe physical access to the community.	<p>Homes in town should be located in typical residential neighborhoods, within walking distance or a short ride to community stores and community services. Rural providers should maintain regular transportation if participants wish to go to the nearest town. Modifications and accommodations in travel or routes to ensure vehicles, sidewalks, curbs, or stairs for participants with mobility impairments have equal and safe access to the community. Participants who are medically fragile should be monitored for safety when transferring and transporting as needed. Procedures and training should be in place for natural hazards (busy roads, ditches, ice, etc...) and using proper accessible routes as needed.</p>
4. Participants have transportation options that result in the ability to access the community when they please.	<p>Providers should teach participants different ways to get rides into the community, including the use of public transit, senior buses, family and friends, and provider vehicles. Participants should also be able to walk or ambulate to community locations within a reasonable distance as much as possible. Providers should provide and maintain an adequate number of vehicles for accommodating participant requests to go into the community. Participants should know how to ask for rides, if there are associated fees, and how far in advance they need to notify the driver that a ride is needed. A suggestion is to include information on fees and how to access rides in a participant/guardian handbook that is reviewed annually.</p>

HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

<p>5. The setting does not use or authorize interventions or restrictions that are used in institutional settings. (e.g. seclusion, involuntary restraints).</p>	<p>Restraints should only be considered when absolutely needed to protect the person from harming themselves or others and if no other alternative strategy has worked. Involuntarily restraints are institutional in nature and should never be used in a HCB Setting. Staff should be trained to restrain a participant in situations where human safety is at stake and should always follow the plan of care for using other less intrusive strategies first every time.</p> <p>The new federal rules specify that <u>any modification or restriction of a right</u> must meet the following requirements and be documented in the plan of care:</p> <ol style="list-style-type: none"> 1) Identify the specific and individualized assessed need. 2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan. 3) Document less intrusive methods of meeting the need that have been tried but did not work. 4) Include a clear description of the condition that is directly proportionate to the specific assessed need. 5) Include regular collection and review of data to measure the ongoing effectiveness of the modification. 6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7) Include the informed consent of the individual. 8) Include an assurance that interventions and supports will cause no harm. <p>Restraints that are not authorized in the plan, used improperly, or used before other attempts at de-escalation must be reported and mitigated by the provider as soon as possible to avoid further danger to the participant or further violation of a participant's rights.</p>
<p>6. The setting integrates non-disabled persons who are not paid staff.</p>	<p>Participants should be encouraged and allowed to host events for friends and family in their home setting. Family and friends should be allowed to visit participants at day service sites during all hours of operation.</p>
<p>7. The setting supports full access to the greater community.</p>	<p>Settings should be conducive to visitors and providers should increase the involvement of the general community with participants in different activities. Providers should have no practice that results in a participant losing the right to access the community or meet with a visitor. If a participant is posing a threat of safety to other people, then the right to access the community may only be limited until the person is no longer posing a threat. No additional punitive restrictions should be invoked. The restriction must follow the requirements listed in number 5.</p>

HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

8. The setting supports and encourages interactions with people in the greater community when participants have visitors or visit community locations, stores, etc.	<p>Participants should be encouraged and supported to go to public events, such as clubs, interest groups, parades or fairs and interact in natural ways with other people. Provider staff should help find events to attend and assist the participant in finding transportation and money for attending as needed. Staff should be trained to encourage participants to interact with members of the community. Settings should have an area available for private interactions between a participant and his/her visitors, if desired.</p>
9. The setting includes opportunities to seek employment.	<p>Provider staff should talk to participants about work, where they could work, and positive work habits such as proper hygiene and attire on a weekly basis or as needed. Providers and case managers should help a participant who wants to work find a competitive integrated job in a field they want to work in. Providers should not restrict a participant's desire to seek employment, a certain type of employment, or increase hours at a job. Providers may need to accommodate a participant's transportation, mealtime, or service schedule because of their job.</p>
10. Employment opportunities include competitive integrated work places.	<p>Day service providers should offer interview and resume help if a person is struggling to find a job, or the provider should ensure another team member helps. Providers-contracted work, provider work sites, or day service sites should provide only short term services to a participant for "work" until a community job is found making at least federal minimum wage and where at least 50% of the workforce not people with disabilities.</p>
11. The setting includes opportunities for persons to engage in community life.	<p>A provider should have a process for exploring a participant's interests in hobbies, cultural or religious traditions, sport teams, or local events to better encourage participants to fully engage in community life.</p>
12. The setting includes opportunities for persons to control personal resources.	<p>Providers should always practice the "least amount of control" rule when it comes to a participant's belongings and resources and have a policy that describes how they will respect a person's rights to personal resources and honor existing payee, conservator, or other court orders.. Participants should control personal financial decisions to the extent the conservator, payee or guardian allows, depending on the court order, if applicable. This right pertains to budgeting, online banking, paying bills, and carrying and spending money. Participants should not be restricted with regards to the use of the money or personal possessions unless they have a conservator or representative payee. Providers and case managers can introduce alternative methods of holding one's money, using debit cards, etc. but should be a coach rather than a banker when it comes to exercising control with a participant in this area. Any required control of funds must be able to be individualized for participants and be detailed in provider policy and given to participants and guardians in a manner they can understand.</p>

HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

<p>13. The setting includes opportunities to receive services in the community to the same degree as persons not receiving Medicaid HCBS.</p>	<p>In conjunction with the case manager, providers should actively seek opportunities and options for the participant to receive community resources, services, or benefits to the same degree as they have. Participants should be given the option to apply for Section 8, public health services, WIC, Paywest, SSI, food bank, or other services or receive religious, civic, or professional services in the community depending on their preferences and needs. The provider policies or practices should not be a barrier to accessing or receiving services to which a participant has a right.</p>
<p>14. The setting is selected by the person from options including non-disability specific settings.</p>	<p>The participant's case manager and provider, as needed, should review possible setting options with the guardian and participants, including onsite tours of different locations owned or operated by the provider, by other providers, or by other local parties in order to identify the preferred setting of the participant. The participant should be provided the option of a non-disability specific setting within their means (such as a private apartment complex with non-HCBS renters).</p>
<p>15. The setting ensures a person's rights of privacy.</p>	<p>Staff should receive training to respect a participant's privacy if assistance is needed in private matters such as toileting or showering. Cameras or similar monitoring devices should not be used unless medically or functionally necessary and approved by the guardian and Division. All staff should be trained to knock first before entering a bedroom or bathroom and not enter the bedroom when no one is present. If a participant needs assistance with dressing, staff should help in private and only to the extent needed.</p>
<p>16. The setting ensures a person's rights of dignity and respect.</p>	<p>The provider should have a policy and a code of conduct in place for staff, similar to the Direct Care Professionals Code of Conduct posted online, that sets a standard for positive interactions with participants. This code, involving respect, dignity, and other ethical standards should be a part of regular staff training. The provider should have procedures in place that record and address violations of that code of conduct (such as retraining or other disciplinary action). Participants and guardians should have a way to voice concerns in this area.</p>
<p>17. The setting ensures a person's rights of freedom from coercion and restraint.</p>	<p>Provider staff should not use any type of coercion or manipulation to intimidate participants or make them do certain activities. Also, chemical, mechanical, or physical restraints should NOT be used as a general rule within an HCBS setting. When they are used, it should be in rare cases when human safety is at risk and only after other less intrusive attempts at de-escalation have been tried as specified in number 5. Restraints should not occur, unless they are a part of the plan of care. Staff should receive proper training from a certifying entity on the use of restraints, if in a participant's plan of care. A procedure or policy should not result in a restraint unless human safety is at risk. A provider must ensure they include a system of monitoring, reporting, and interviewing participants to ensure coercion is not being used with participants. A provider must also have a monitoring system if and when restraints or restrictions are used on participants to ensure they are used properly and as a last resort, retraining or taking disciplinary or follow up action with staff as necessary.</p>

HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

<p>18. The setting optimizes a person's independence in choosing daily activities.</p>	<p>Providers should have a systematic practice in gathering input from participants on their daily schedules and involving them in planning activities. Participants should have an opportunity to give input or feedback on planned and unplanned activities so their schedule can meet their individual needs and preferences. Participants should not be forced to participate or punished for changing their mind. Providers should honor participant wishes whenever possible (an exception would be bad weather) and find ways to be flexible when possible. These processes should be outlined in a participant handbook with evidence of meetings or input given upon request.</p>
<p>19. The setting optimizes a person's independence in choosing his or her physical environment.</p>	<p>Providers, in conjunction with the case manager, should provide participants the reasonable opportunity to change physical location if the participant desires. Participants should be shown different options for service environments annually if they are interested or showing dissatisfaction with the current setting.</p>
<p>20. The setting optimizes a person's independence in customizing his or her physical environment.</p>	<p>Providers should have a method of gaining input from participants on decorating a service setting, especially one's bedroom and home environment. Participants should have the opportunity to decorate their setting. Limitations on decorations must be specified in a lease agreement in similar documentation.</p>
<p>21. The setting optimizes a person's ability to choose with whom to interact.</p>	<p>Participants should be allowed to give input on who they want to interact with and the providers should try to make those interactions happen. Staff should encourage participants to self-advocate in this area. Procedures should be in place to resolve any potential conflicts between participant preferences and provider preferences.</p>
<p>22. The setting facilitates personal choice regarding services and supports.</p>	<p>Case managers and providers should work together to gather participant and guardian input on preferred services and supports so they can develop a plan of care reflective of those preferences. Sometimes a service is still wanted, but the person wants to receive it differently, or receive supports differently, and there should be at least an annual check in with the participant or guardian to see if changes are needed.</p>
<p>23. The setting facilitates personal choice regarding which provider provides services.</p>	<p>Providers should seek input on the participant's preferences in staff or the type of staff that are the best fit. If multiple participants and guardians request a small number of staff, providers should have a policy in place that ensures participants have fair access to their preferred staff as available or appropriate.</p>

HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

<p>24. Each person in the residential setting has a signed lease or written residency agreement.</p>	<p>Providers must ensure a lease or written agreement is in place for each participant who leases or rents a room or apartment from the provider. The agreement must afford the participant the same protections from evictions as the general public. The leases <u>should</u> also include the specific room and location of the lease, any limitations on visitors, decorations, or access to food or certain sections of the unit. If some of these items are not in the lease but in other forms or agreements, then the provider may not have these items in the lease. The Behavioral Health Division will provide support to providers who are developing this agreement for the first time.</p>
<p>25. Each person has privacy in their sleeping or living unit.</p>	<p>Case managers or providers should ensure participants who are in residential services are presented with an option to have their own room if they currently share a bedroom with another person. The choices offered and decided should be documented in the plan of care. For privacy, provider staff should be trained to knock first before entering. Monitoring systems should be in place only if medically or functionally necessary and approved by the Division and Guardian. If sharing a bedroom, the provider must configure a way for the participant to have privacy available to them in their area.</p>
<p>26. Each unit has lockable entrance doors (bedroom and house door) with access to the lock, along with appropriate staff having access.</p>	<p>Providers must ensure participants have lockable rooms, and residences should have lockable entrances. Participants should have a key to their unit and bedroom or be given the option to have their own key or another way of gaining secure access to the location, such as a key pad. Any modifications to this right must follow the process in #5.</p>
<p>27. Each person sharing a sleeping or living unit has a choice of roommates.</p>	<p>Providers should encourage roommate situations that work best for the participants who have to live together and allow for their input into these decisions. The process and decisions must be documented. The process for offering choice should be in a participant handbook or similar documentation.</p>
<p>28. Each person has the freedom to furnish and decorate within the lease or agreement.</p>	<p>The provider should be flexible with the desire for participants to individualize their living area. The process for getting their input and helping them decorate should be in a handbook and limitations specified in the lease agreement sent to the Division.</p>
<p>29. The persons do not have to follow a regimented schedule during services in this setting.</p>	<p>The provider should have a policy and procedure for staff to follow when a participant decides to decline services, not participate, or changes their mind. The participant must not be coerced into receiving services against their will.</p>

HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

<p>30. Each person has the freedom and right to support and control his/her own schedule and activities.</p>	<p>The provider should not regiment activities to the extent that participants cannot individualize their daily activities and have schedules that may vary some from one housemate to another. The provider should have a systematic way to gather input into schedules by the participant and require staff to report, and respond if possible, to any desired changes or and choices in alternate activities. These processes should be included in the participant handbook.</p>
<p>31. Each person has the freedom and right to support to access food at any time.</p>	<p>Participants should have the right to access the food they have purchased with room and board or personal resources, unless there is a medical restriction. Even with a restriction, the process listed in #5 must be followed according to the new federal rules. Participants should have the option to cook their own meals and receive support to do this task. Participants should have the option to choose the food they want to eat and receive support as outlined in the plan of care. The provider's process for providing access to food, any possible limitations, and how they will support participants in an individualized manner should be in a participant handbook.</p>
<p>32. Each person can decide <u>when</u> they want to eat.</p>	<p>Providers should allow a mealtime schedule to be personalized and have a formal process for checking in with a participant on any changes they want to make on when they eat or prepare meals to eat.</p>
<p>33. Each person can decide <u>with whom</u> to eat.</p>	<p>Participants should freely decide with whom to eat with. Participants should be able to invite friends or family to eat with them. These areas should be included in the provider's individualized scheduling process and there should be a process for gathering the participant's input.</p>
<p>34. Each person may have visitors at any time.</p>	<p>Day service facilities should be open to visitors during all open hours. Residential settings should be open to visitors during reasonable hours (e.g. 9am – 9pm). Providers may adopt a visitor policy to ensure visitors are on an approved list and safe for the participants (providers may want to adopt this within the lease agreement). The visitor policy should be able to accommodate new people in a reasonably quick timeframe. Furthermore, providers should encourage family, friends, and community members to visit participants in these locations to help develop new social networks, help participants maintain friendships, and improve the quality of the person's social life.</p>
<p>35. The setting is physically accessible to each person in it.</p>	<p>All settings should be fully accessible to participants with physical disabilities who are receiving services there. This is not just ensuring ADA compliance, since many mobility devices are different sizes. Ensure that participants you choose to serve can access the different parts of the building they should have access to with their preferred mobility device.</p>

HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

Example of a Provider Transition Plan for one area of non-compliance

TRANSITION PLAN (FROM JUNE 2015 TO OCTOBER 1, 2018)

COMPLIANCE TOPIC

XYZ Industries waiver service settings must include opportunities for participants to control personal resources.

MILESTONE

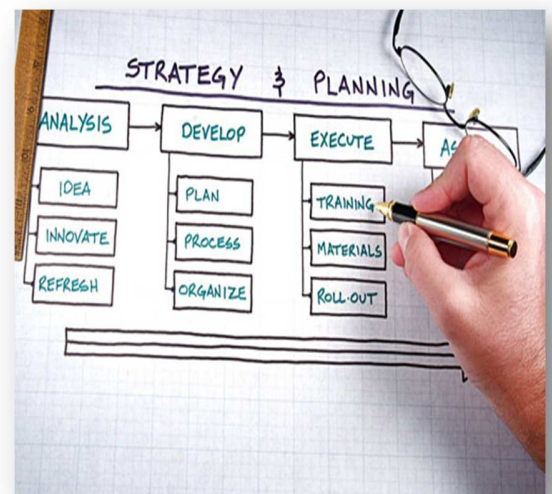
1. By June 30, 2016, XYZ Industries will include information in our participant guidebook that offers various options for the participant to exercise control in their finances, such as helping a participant open a debit card account, use a debit card for purchases, conduct online banking, and giving the participant with a payee more control of paying bills and tracking receipts.
 - a. The Day Service program manager will research options available by December 30, 2015.
 - b. The Administrator will review the options and update the policy and procedures to reflect the new options and how the agency will process requests by February 28, 2016.
 - c. The Day Service program manager will update the participant guidebook to include the options by January 30, 2016.
2. By June 30, 2016 XYZ Industries will train XYZ staff and participants on the options available and on how to ask for these options to be implemented.
 - a. The Day Service Program Manager will hold three trainings in April and May 2016 to train participants, guardians and staff on options available and how to ask for an option to be implemented.

Example is on the BHD Website at: <http://www.health.wyo.gov/ddd/index.html>

Transition plans must include detailed milestones for each area of non-compliance, action steps, and deadlines. Transition plans should ensure that each area of compliance is systematically applied in the organization and all participants are afforded their rights. Policies and procedures should be updated when making a systemic change and be implemented with training for staff, participants, case managers and family members/guardians. They should also be evaluated regularly to see if they are effective.

Annual progress on the transition plan is required and must be reported to the Division *each year* by October 1.

If concerns arise with the new standards, BHD may issue corrective action to have the provider address the issue. Provider Transition Plans are due by October 1, 2015 to BHD.



HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

Key Terms - Definitions and Guidance

Integration

From the new CMS Community Living Rule for waivers section 441.301

The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

The setting facilitates individual choice regarding services and supports, and who provides them.



HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

From the Americans with Disabilities Act (ADA)

Integration is fundamental to the purposes of the ADA. Provision of segregated accommodations and services relegate persons with disabilities to second-class citizen status. The ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them.

From the Department of Justice

In general terms, integrated day activities:

- Are activities not related to supported employment
- Are integrated within the community
- Are individualized to the individual's preferences, and
- Promote individual growth toward increased independence.

In other words, integrated day activities are meaningful, nonpaid community activities, involving persons not paid to be in the individual's life, accomplished during normal daytime periods of activity, including weekends, when a person is not working in supported employment.

For those who do not work 40 hours a week and those served in congregate day support facilities, they should be offered integrated day activities that are true to the principles above.

In addition, integrated day activities should be tailored to the individual's preferences. The activities should be person-centered and based on an individual's choice of what they want to do after being provided a range of options. The options should not be limited because of convenience. Integrated day activities must promote individual growth toward increased independence. More specifically, they should promote competence, independence, and socialization; should enhance family ties, adaptive skills, and psychosocial skills; should support physical and mental health; and should allow individuals to contribute to society and develop intimate relationships in the community. At its foundation, these activities should challenge the individual to take charge of their life.

“I want to be included and part of everything, just like my family. I don't want to wait until all my housemates want to eat or go somewhere. I want to be able to do things on my own, hang out with friends, and meet new people. I just want to be seen as an equal.”
~ Self-advocate

Integration characteristics from the HCB Setting Transition Taskforce Members

- Incorporated as equals in society
- Fully included
- Having the ability to partake in community life on one's own terms
- Developing meaningful relationships outside of the paid caregiver
- Access to the community at any time
- Being an active part of the community
- Building relationships that lead to employment, which builds self-esteem
- Integrated to fullest extent possible
- Foster community options
- Have access to competitive employment
- Seek like-minded activities with people in the community so the person can do preferred activities with others who like same thing
- Balancing choice/risk/provider liability
- State backing providers to let people learn consequences
- Real discussions with the person during meetings-do decision making as a team
- Integration is not a one-size fits all
- Choice in all aspects of their life
- Sometimes our situations restrict us (but our disability should not)
- Some people can't articulate choice, but their strengths can help give a more normalized life

HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

- Offer different options to people so they can make more informed choice
- Equal options/fairness/social justice
- A home and all things that go with "home"
- Having friendships relationships with people of one's own choice
- Help setting reasonable and realistic goals
- Give choice in setting
- Working several jobs
- Doing things in community to make changes happen
- Doing everything like other people
- Getting involved
- Listen to the person-what is effective for them
- Being with the general public (non-waiver funded)
- Integrated activities (with members of clubs, like-minded interests)
- Living and being like everyone else
- We are all just people (quit grouping people together)
- Building relationships both ways by learning from each other – people who we serve often teach us
- I Love doing stuff at the hospital, school, volunteering
- We want the choice of doing old and new activities – some will still like day services at a center and Special Olympics that may not be fully integrated
- Providers being as invisible as possible when supporting a person
- Building relationships everywhere (from state to providers to participants and to community members)
- Joining together to combine resources and accomplishing more
- meaningful choice may require more funding

Inclusion

From the Developmental Disabilities Assistance and Bill of Rights Act of 2000

The term "inclusion", used with respect to individuals with developmental disabilities, means the acceptance and encouragement of the presence and participation of individuals with developmental disabilities, by individuals without disabilities, in social, educational, work, and community activities, that enables individuals with developmental disabilities to:

(A) have friendships and relationships with individuals and families of their own choice;

(B) live in homes close to community resources, with regular contact with individuals without disabilities in their communities;

(C) enjoy full access to and active participation in the same community activities and types of employment as individuals without disabilities; and

(D) take full advantage of their integration into the same community resources as individuals without disabilities, living, learning, working, and enjoying life in regular contact with individuals without disabilities.



HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

Institutional Qualities (what we don't want to see)

From the Olmstead v L.C. Supreme Court decision

In its 1999 decision in *Olmstead v L.C.*, the Supreme Court found that the institutionalization of persons with disabilities who were ready to return to the community was a violation of Title II of the Americans with Disabilities Act (ADA). The court also found that confinement in an institution severely diminishes everyday life activities, including “family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

From the Department of Justice on “Institutional nature”

By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.”

From the new Federal HCBS Rule:

Settings that are not Home and Community-Based: Home and community-based settings do not include the following:

- i. A nursing facility;
- ii. An institution for mental diseases;
- iii. An intermediate care facility for individuals with intellectual disabilities;
- iv. A hospital; or
- v. Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

From an additional CMS Guidance document:

Settings that have the following two characteristics alone might, but will not necessarily, meet the criteria for having the effect of isolating individuals:

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
- The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.

Settings that isolate people receiving HCBS from the broader community may have any of the following characteristics:

- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
- People in the setting have limited, if any, interaction with the broader community.
- Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

Descriptions of Institutional qualities from the Transition Taskforce members

- Passive in nature, not “active”
- Participant is ignored
- Waiting to be told what to do
- Things are regulated
- Not building relationships
- Services come to a person rather than a person going to services
- Choices are made as a group, not as an individual
- One-stop shopping for services
- Everyone doing things at the same time
- Institutions are very different in history and in life now
- It is unfair to group people with disabilities
- No freedom
- Very restrictive
- Not being able to choose
- People/things are very uniform
- Structured pattern everyday
- Restrictive schedule, not having choices or freedom
- Being told what to do without being part of the decision process
- No control over little things or big things
- Thinking there is only one way to do things
- These descriptions mean our families could be considered institutional
- Institutional delivery is efficient for staffing and taking care of people when funding is limited
- Group services of any kind with a segregated population
- Groups of 6+

Informed Choice

From the new federal HCBS rules and their responses to public comment

A provision has been added at § 441.301(c)(2)(i) to read: “Reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

The person-centered planning process provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions... and Offers informed choices to the individual regarding the services and supports they receive and from whom.

States must ensure that when an individual chooses a home and community based setting, the individual has made an informed choice among options. In the event the individual has made an informed choice to reside in a setting that provides both housing and services, the individual must acknowledge that he has also chosen that provider to be the service provider. Our decision not to require the separation of housing and services in the final rule does not preclude a state from structuring its service delivery system to promote separation. Nor does it preclude a provider from allowing for such an arrangement if all parties agree, and the arrangement does not violate state licensing requirements.



HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

Wyoming Medicaid Rules

Informed choice-A decision made by a participant or guardian if applicable that is made voluntarily, without coercion or undue influence, and that is based on sufficient experience and knowledge, including exposure, awareness, interactions, and/or instructional opportunities, to ensure that the choice is made with adequate awareness of all the available alternatives to and consequences of options available.

From Taskforce discussions and Vocational Rehabilitation literature

What are some of the choices the waiver participant can make?

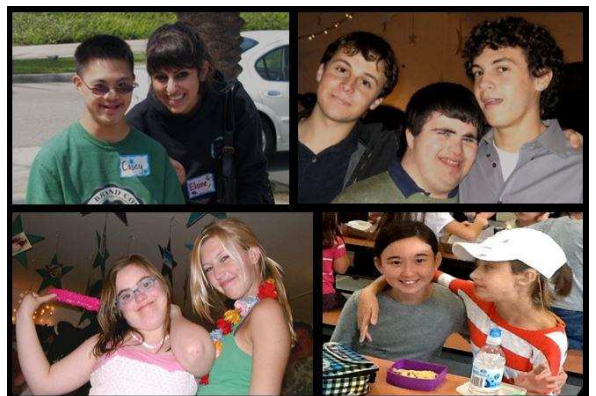
- The goal that fits their interests, talents, needs, and values.
- How much help they want to develop their individualized plan of care.
- The services needed to support the person the best, in the most integrated manner.
- Who provides services
- To help take responsibility for one's choices and understanding the possible outcomes and consequences to choices. In terms of choice, a provider says talking with the participant about their choices has changed, including downloading brochures and talking them through each brochure of their options
- One entity suggested that provider fairs would be a way that participants could do a round robin to ensure that they have choice in services. He also mentioned a train the trainer for job coaches.

Making choices in the waiver program does not mean the person can have anything they want. And the choices must make sense and give good value to the person's life and be reasonable in cost. And they must help reach their goals. Services need to be chosen because a person needs them, not just wants them.

Focus on Friendships

Ideas from the Taskforce about helping waiver participants develop and maintain more friendships so they do not just have paid staff or family in their lives

- Service settings should help people have new and exciting experiences and meaningful relationships.
- Shared reciprocity opens up independence, job opportunities, and self-determination.
- The highest aim in life is friendship.
- Participants may need training regarding "healthy relationships" and discuss instances of exploitation. They may need supports to maneuver society.
- Finding a job is related to finding new friends. Getting out there and getting a public face helps participants meet new people and acquaintances may turn into friendships.
- Help participants hold a nice dinner-gathering with friends.
- It is important for people to expand their circle of friends and have hangouts at home. Nothing big has to be planned, maybe just playing video games or cards or watching a



HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

show or game on tv together.

- One girl on the waiver started using the city bus each day and slowly developed a friendship with a bus driver, who also looked out for her along the daily trips she took.
- Wherever a person lives, even in a group home, talk to residents/participants about what it is to be a good neighbor. Help them meet the neighbors. It is important to have neighborhood gatherings and teach caution and safety.
- One agency has volunteer partnerships and is finding through these partnerships, participants are making natural friendships.
- This would be hard to measure. We need to be careful about saying that people need to have a certain number of friends. Experience breeds choice and providing lots of new varying opportunities to develop these kind of relationships. It is important to flood people with opportunities. Most of our socialization comes from the work environment.
- Being an introvert, some people may dislike being forced into opportunities; people need to be sensitive of this.
- We have to respect that many people have friendships that are served within their circle.
- The State asked the question if friendships are still continuing if there is a change in providers. Some providers try to help friends get together occasionally but there is a drop off of helping people stay connected when providers change. One mom mentioned that these friendships should be listed in the plan of care and on their schedules so the team sees them as important to maintain.
- Unity in the community. Sheridan hosts by gathering in the park. They invite community members and advertise on the radio.
- Technology can work in keeping those friendships together.
- Some providers and family members feel that education is important with regards to how some people may communicate, i.e. non-verbal, etc. so that others will approach them and talk and so the participant has more opportunities to connect with people.
- Give participants the right to technology...some organizations are proactive in assisting people with Facebook, texting, etc. so they can be in touch with people they know, like and love ... just like anyone else does these days!
- Some providers have Computers and iPads that participants can use. She has noticed a huge increase of communication for participants using Facebook and connecting with friends. "It has been great."
- One provider started an internet café and has several people using Facebook.
- There are struggles with higher needs folks and education needed for older guardians on technology and how people have friends and communicate. Some providers are trying to provide this education.
- Providers may need to find a class or teach responsibilities and dangers of internet interactions to participants as they become skilled users of the Internet.



HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

Access to food when a person wants to eat

A few providers have brought up how difficult this right to food may be in a group home setting. Many group homes pool resources to purchase food for primary meals using commodities program. They pose the question, “what do you do when a person eats all their food and has no money with 2 weeks left”? What if other people in the home are affected?

Here are some ideas and responses from the taskforce:

- The person’s payee and team can work together to get solutions, maybe shopping every other day, make smaller purchases, etc.

Response: It may cost more shopping every other day.

- Another provider said their organization had people restricted from food and they couldn’t remember why. He encouraged people to not restrict or deny access because of things that have happened in the past.



The new rules require a team to validate that the restriction is on target. Still, there are many questions:

- What is that going to look like in plan of care if a guardian restricts for no reason?

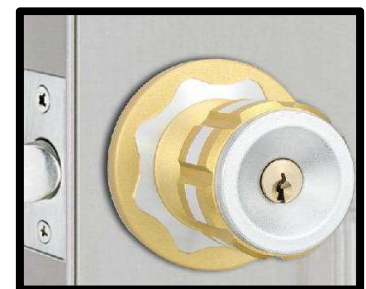
Response: The plan must include the specific assessed need and document the positive interventions that will be tried before the food is locked up and the right is restricted. The team should give due diligence in the plan of care about safety, including the opportunity for the person to learn new skills and be trained on the pros and cons to certain food choices. No one can guarantee 100% that someone won’t be hurt in either option (restricting or not restricting).

Signed Lease or Residency Requirement

The new rules require a person living in a provider-owned or -operated facility to have a signed lease in place. Why is this important? A lease sets forth the rights and responsibilities of both the landlord and the tenant. When a participant is paying room and board to a provider that affords them rights as a tenant. The lease captures the amount of rent, responsibilities for other charges or activities for both the owner and the tenant/participant. The lease cannot bound a person to waiver services and it cannot keep the person from giving a 30 day notice to change providers and vacate the property. As with any legal paperwork, the lease should be seen by those who may help the participant carry out their responsibilities before signing it. The lease should designate which home and room is being rented, amount of rent, due date, other allowable charges, information on decorating the area to one’s preferences, whether smoking, pets, or other items are allowed. Regulations on noise or things that would be grounds for eviction should be included. The lease should explain how the tenant/participant can request repairs and emergency requests.

Access a Lockable bedroom door and front door

The new rules require the participant to have access to a lockable door for their bedroom and home. This is important to allow the person protection of their property, privacy, and a way to secure their home. Many people have voiced concern over participants losing keys, giving them away, or not knowing how to use them. To comply with the new rules, providers should explore different types of locks, key codes, and ways of teaching participants how to be responsible with the key. Other participants may need support in having a key or key code and unlocking their room, which needs to be in the plan of care.



HCB Setting - Improvement Process

Guidance for Case Managers, Providers, Participants, & Guardians

Guardian Input and Decision Making

Court appointed guardians play a critical role in helping participants with making some major life choices. Guardians are given the responsibility of making macro-level decisions for a person under their guardianship, such as choosing medical or waiver providers, treatment, and signing legal agreements or contracts. The guardian should be advocating for the person and making choices that honor the person's preferences, unless the choices may bring the person harm. The day to day decisions about what clothes to wear, where to eat, what to do, and who to hang out with should be decisions that the participant can make without the guardian's input...once again, unless there is a real risk of harm in one of those choices. The Wyoming Guardianship Corporation (WGC) is helping the Division try to dispel old thoughts about guardianship through teaching how to support people through guardianship. They describe guardians as the "first mate" of the ship and the individual as the captain driving his/her own services. Guardians may need to be pointed to training opportunities or may need to talk through these changes if they are disagreeing with the new rights and restriction requirements in plans. BHD and WGC teamed up to create a Guardianship handbook and training, available on the BHD website: <http://www.health.wyo.gov/ddd/index.html>

Case managers, providers and state staff have to be sure that guardians have the authority to make certain choices, so they will review guardianship papers and the guardianship statute to double check. The guardian and IPC team should ask "Why is this restriction needed?" "What have we tried before to avoid restricting the right?" "Do we really know what will happen if this right is fully respected (not restricted)?" "What can we teach or how can we support the person to exercise the right safely without restricting it?" If the team has not discussed these questions, then the right is likely restricted without good evidence to support it.

Sparking change!

Taskforce members are making changes due to the new rules and the waiver redesign...and because they felt it was the right thing to do!

- A larger organization identified 22 people living in residential habilitation that did not need probably need to be in residential habilitation services. They began talking with staff, participants, and guardians about how to transition people into more independent settings. After a few agreed to move, they began transitioning a few folks into more independent settings using the proper supports. They are using remote monitoring (technology sensors, 2-way communications, etc.) and stepping down supervision as the participants feel more comfortable without staff being available all the time.
- The state has met with providers and go over how to "create a meaningful day for people with developmental disabilities." Getting out and talking to people and providing professional development to provider employees helps spark the need for change and new approaches.
- An organization is putting people in apartments so they had an empty group home. They talked to some ladies (on the waiver) who were close friends to see if they wanted to take over an empty group home as their own home. So the three ladies lease it now and call the shots in the home. It is not round the clock care. It is a small step toward independence and they are increasing their self-determination and authority over roommates, staff, and when help arrives and leaves.



HCB Setting - Improvement Strategies

Guidance for Case Managers, Providers, Participants, & Guardians

- State managers have met with several agencies to talk about how they can implement the new HCB setting requirements and how they can make it work... developing a partnership.
- A larger provider shared that his organization purchased an employment curriculum that will have 10 trainers statewide and spread employment services. He also referred to a stakeholder group to help interpret the CMS rules and help design meaningful outcomes and services.
- A parent on the taskforce helped his son and two friends purchase a home. He says that building a life worth living includes home ownership and becoming part of the community.
- A northern provider added dozens of new volunteer partners. They are training families on informed choice and running IPC meetings differently. They have added keypad entries and participants are out in the community more than 50% of the time. 1/3 of participants are on employment tracks. They are also attending regular meetings with the Division to discuss challenges and successes. She feels this has been good for their organization.
- The Wyoming Governor's Council on Developmental Disabilities is promoting awareness and assisting people in finding options. They also contracted with Bridges to do provider expos and will be doing 6 regional expos in 2015. They have also headed up the Employment Summit each year and is geared toward different audiences (employers, people with disabilities, etc.)
- A case manager said she feels that it has been critical to use person-centered planning and hearing what the participant is saying when writing up the plan of care to ensure that it identifies what is specific and important to the person not what we or the providers want.
- Another provider said an individual employment plan should be done on every person based on the person's needs, wants, and desires so the person can get their dream job. He feels it takes a systematic approach on each item on the checklist.
- A parent in the Western part of Wyoming stated that in his community they are building a greenhouse and employing 10-18 people, which creates skills for people who want to work at the greenhouse. They are going to be integrated and build leadership opportunities among staff.
- Another provider stated that their organization is doing a one-on-one sit down with each person and asking "what is it that you want to do with your day"? Then they start making that happen.

One provider helped a man purchase a home that was accessible for him.

They also moved 2 individuals into their own apartment from a group home, who are now paying their own bills, utilities, etc. The provider expressed that he finds that guardians and families are afraid of making these changes, but as they see progress and very few drawbacks, they slowly agree to more. The provider says some guardians may always stay resistant to change, though.

“I want my adult child with autism to have providers who focus regularly on cognitive growth, interpersonal skills, and leisure management when delivering services and planning activities. Providers need to keep participants engaged and involved, helping them to be life-long learners!”

Page 26

director said the plan of care goals should be ownership, get married, take a vacation, etc. be meaningful outcomes that can be in the person-centered planning process, should be dreams. Home ownership and part of the community should be talked often so the team can work to make it

” –Taskforce Parent

HCB Setting Transition Taskforce Members Include:

- Wyoming Guardianship Corporation
- Wyoming Governor's Council on Developmental Disabilities
- Wyoming Department of Health, Behavioral Health Division
- Wyoming Department of Health, Office of Healthcare Financing
- Protection & Advocacy System, Inc.
- Self-advocates on the waiver
- Parents of people on the waiver
- Guardians
- Case Managers
- Providers (NOWCAP, ARK, RESCARE, LSR, LIFE SKILLS)
- Assistant Attorney General

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